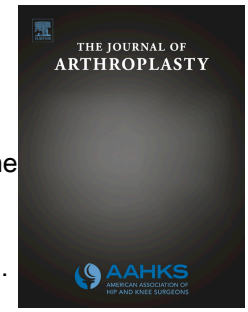

Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.




# American Association of Hip and Knee Surgeons Advocacy Efforts in Response to the SARS-CoV-2 Pandemic

James I. Huddleston, III, MD, Richard Iorio, MD, Joseph A. Bosco, III, MD, Joshua M. Kerr, MA, Deputy Executive Director, Michael P. Bolognesi, MD, C. Lowry Barnes, MD

PII: S0883-5403(20)30437-X

DOI: https://doi.org/10.1016/j.arth.2020.04.050

Reference: YARTH 57970

To appear in: *The Journal of Arthroplasty*

Received Date: 16 April 2020

Revised Date: 17 April 2020

Accepted Date: 17 April 2020

Please cite this article as: Huddleston III JI, Iorio R, Bosco III JA, Kerr JM, Bolognesi MP, Lowry Barnes C, American Association of Hip and Knee Surgeons Advocacy Efforts in Response to the SARS-CoV-2 Pandemic, *The Journal of Arthroplasty* (2020), doi: https://doi.org/10.1016/j.arth.2020.04.050.

# American Association of Hip and Knee Surgeons Advocacy Efforts in Response to the SARS-CoV-2 Pandemic

James I. Huddleston, III, MD*, Richard Iorio, MD, Joseph A. Bosco, III, MD, Joshua M. Kerr, MA, Michael P. Bolognesi, MD, C. Lowry Barnes, MD

*Corresponding author:
James I. Huddleston, III, MD
Department of Orthopaedic Surgery
Stanford Healthcare
Stanford, CA 94305
jhuddleston@stanford.edu
650-721-7661 (o)

Richard Iorio, MD
Department of Orthopaedic Surgery
Brigham and Women's Hospital
Harvard Medical School

Joseph A. Bosco, III, MD
Department of Orthopaedic Surgery
New York University

Joshua M. Kerr, MA
Deputy Executive Director
American Association of Hip and Knee Surgeons

Michael P. Bolognesi, MD
Department of Orthopaedic Surgery
Duke University

C. Lowry Barnes, MD
Department of Orthopaedic Surgery
University of Arkansas

# American Association of Hip and Knee Surgeons Advocacy Efforts in Response to the SARS-CoV-2 Pandemic

Abstract:

As soon as it became clear that our economy was going to be paralyzed by the SARS-CoV-2 pandemic, AAHKS leadership acted swiftly to ensure that our members were going to be eligible for the anticipated federal economic stimulus. The cessation of elective surgery, enacted in mid-March and necessary to stop the spread of the SARS-CoV-2 virus, would surely challenge the solvency of many of our members' practices. While our advocacy efforts discussed below have helped, clearly more relief is needed. Fortunately, our mitigation efforts have led to a "flattening of the curve" and discussions have begun on when, where, and how to safely start elective surgery again.

As of April 16, 2020, the dashboard from the Center for Science Systems and Engineering at the Johns Hopkins University reported more than 2.1 million confirmed COVID-19 cases and 142,000 deaths globally. In the United States, we have more than 650,000 confirmed COVID-19 cases and 31,600 deaths, the most of any country. The more than 2400 deaths reported by the United States on April 15, 2020 represented our deadliest day of the pandemic yet. The disproportionate number of cases in the United States is in part due to population concentration, an inability to easily socially distance from one another, and a reluctance to restrict travel. For example, the two US COVID hotspots, New York City and New Orleans, are both densely populated and are tourist destinations.

Despite the grim numbers, there are early signs that the stringent mitigation efforts, with now nearly 97% of all Americans under shelter-in-place orders until at least April 30, have been effective in "flattening the curve", and hopefully, preventing our hospital systems from becoming overwhelmed with COVID-19 patients as was seen in Italy. New York, with the most cases in the United States, is now seeing reduced numbers of new admissions and intubations for COVID-19 with more recovered patients than deaths. In the San Francisco Bay Area, where a shelter-in-place order went into effect on March 16, three straight days of reductions in both hospitalized patients as well as patients in the intensive care units have been reported. These data have allowed California to send stockpiles of personal protective equipment (PPE) as well as healthcare workers to hot spots in New York and New Jersey. The next "hot spots" appear to be Texas as well as the Metro Washington, D.C. and Maryland areas.

Congress has taken decisive actions to minimize the economic effects of the lockdown. More than 22 million Americans have filed for unemployment in the last four weeks. On March 5, the House and Senate unanimously passed H.R. 6074, the Coronavirus Preparedness and Response Supplemental Appropriations Act, an $8.3 billion emergency funding measure. This bill, commonly known as the "Coronavirus Supplemental" was signed into law by President Trump

the following day. The majority of the funding in the law went to the Department of Health and Human Services (HHS) to foster development of vaccines and testing kits, to the federal government to assist in the international response to the pandemic, as well as to local and state governments for laboratory testing equipment and staffing increases in preparation for a surge in cases. The American Association of Hip and Knee Surgeons (AAHKS) recognized this as an important "first step" in our country's response, and our advocacy efforts have included a recognition and appreciation to Congress and the Administration for this timely move.

The second stimulus package, H.R. 6201, the Families First Coronavirus Response Act (FFCRA), was signed into law by President Trump on March 18. It provided affected individuals with sick and emergency leave, created tax credits for affected employers, expanded food and nutrition services, gave states and territories emergency unemployment grants, and increased federal matching funds for state Medicaid programs. The eventual total funding under the law is estimated to be $180-350 billion once all benefits have been realized.

The emergency medical and sick leave expansions in the FFCRA establish benefits and employer requirements for paid leave related to the public health emergency. The employer requirements apply to businesses with 500 or fewer employees, and there are limited federal tax credits established to help defray costs. However, recognizing that small businesses may not have the resources to provide these expanded benefits, there is a provision allowing the Secretary of Labor to make exemptions for businesses with fewer than 50 employees. AAHKS partnered with the American Academy of Orthopaedic Surgeons (AAOS) and supported these provisions also, and our advocacy included a request that our many members who participate in the private practice of joint replacement are fully-recognized as qualifying small businesses.

The FFCRA also established requirements for all public and commercial insurance to cover coronavirus diagnostic tests as well as visits that result in the administration or ordering of such a diagnostic test. In order to eliminate financial barriers to being tested, these items and services are required to be covered without any out-of-pocket costs for the patient (including copays, coinsurance and deductibles). For the uninsured, the bill established a 100% federally-funded state option to expand Medicaid for those same diagnostic services. Curiously, the bill also appropriated $1 billion to the National Disaster Medical System to reimburse providers for COVID-related testing services for the uninsured, but it is unclear how that will be implemented in concert with the optional Medicaid expansion. To date, Congress has not established a specific commercial insurance coverage requirement for the *treatment* of coronavirus/COVID-19. As Round 4 legislation is being crafted, AAHKS is encouraging lawmakers to protect patients and close coverage gaps for patients who are receiving ongoing treatment for COVID.

On March 27, President Trump signed H.R. 748, the Coronavirus Aid, Relief, and Economic Security (CARES) Act. At a cost of $2.2 trillion, this legislation represents the largest economic bill in the history of the United States. It provides 100% forgivable loans, capped at the lesser of $10 million or 2.5x the average monthly payroll costs for the preceding year, to small businesses with fewer than 500 employees (Paycheck Protection Program). Other provisions include suspension of the 2% Medicare cuts ("sequestration"), a refundable tax credit for the

Social Security Tax, a payroll tax deferral, suspension of principal and interest payments on federal student loans, advance Medicare payments for providers and $100 billion in relief specifically for the healthcare industry. AAHKS fully supported this approach and saw this as significant economic relief to many of our members and trainees.

Even before final passage of the CARES Act, leaders from AAHKS were already crafting a response with leaders from the AAOS. Our goal was to share how orthopaedic surgeons were being affected by the pandemic, most notably due to the cessation of elective surgery aimed to slow community transmission of the virus and to conserve valuable PPE for those healthcare workers on the front lines. Our letter was sent on March 31 to Eric Hargan, Deputy Secretary of the United States Department of Health and Human Services. It cited recent data from AAHKS members showing that of the nearly 700 respondents, 92% had stopped all elective surgery, 50% had furloughed staff, 58% are foregoing payments to keep their practices open, 49% reported significant financial distress, and 47% were seeking relief through the CARES Act. Our requests included: making orthopaedic surgeons eligible for part of the $100 billion approved for the healthcare industry, making no change in the 2021 Medicare Physician Fee Schedule for primary hip and knee replacement, and restricting losses to participants in the two advanced alternative payment models from the Centers for Medicare and Medicaid Innovation (CMMI), the Comprehensive Care for Joint Replacement (CJR) and the Bundled Payment for Care Improvement – Advanced (BPCI-A) initiatives.

The letter triggered a request for a follow-up phone call with HHS leadership on April 7. HHS assured AAHKS and AAOS leaders that physicians were indeed eligible for part of the $100 billion allocated in the CARES Act and that details were to be provided after the formal announcement from Seema Verma, Centers for Medicare and Medicaid Administrator, later in the day as part of President Trump's daily briefing from his Coronavirus Task Force. A letter from Congressman Brad Wenstrup, DPM (R-OH) and 14 other members of the "Congressional Doc Caucus" that had previously been sent to Alex Azar, Secretary of the United States Department of Health and Human Services, likely helped bolster our concerns on this important issue. Other issues discussed on the call included the 2021 Medicare Physician Fee Schedule for primary hip and knee replacement as well as COVID-19 impacts on CJR and BPCI-A. Due to the bundles being flooded with "high risk" patients, AAHKS asked for CMMI to expedite the release of Net Payment Reconciliation Amount payments, to delay negative reconciliation payment timelines or allow for certain forgiveness allowances, as well as to provide additional guidance for conveners to share their receipts from CMMI immediately with physician group practices.

On April 10, guidelines were released for disbursement of an initial $30 billion tranche of CARES funds for healthcare providers. These funds represent grants, not loans, that will be distributed to all providers based on the recipient's proportional share of 2019 Medicare Fee-For-Service (FFS) reimbursements. The calculation does not include Medicare Advantage (MA) or Part D revenue, so those arthroplasty practices with a high percentage of MA patients may see lower payments compared to practices with high traditional Medicare patient mixes. It is estimated that this will total about 6% of an average 2019 FFS reimbursement. Further, no application is needed as disbursement will be accomplished via direct deposit. Physicians have 30 days to

acknowledge receipt of the grant and to agree to the terms and conditions. HHS will be releasing additional tranches of funding to physicians and other providers which will target COVID hot spots and seek to plus-up those providers who were not advantaged by the first tranche's methodology (e.g. a Medicare Advantage adjustment). HHS will also hold back a portion of the $100 billion fund to respond to the pandemic as needs shift over time. AAHKS continues to be engaged with HHS for relief that will target the specific need of our members' practices.

AAHKS is also seeking to amend the requirements of the Medicare Accelerated and Advance Payment Program which was expanded under the CARES Act. The program allows physicians to receive an up-front payment equal to 100% of their Medicare payment amount for a three-month period. A total of $34 billion was distributed through this program already, and Medicare Administrative Contractors are processing new applications. Currently, the Centers for Medicare and Medicaid Services (CMS) will begin to recoup that up-front payment after 120 days. Congressman Mark Green, MD led a letter to Congressional leadership highlighting that the recoupment period was much shorter than other relief programs in coronavirus legislation. His letter goes on to recommend a phased recoupment beginning on December 31, 2021 and allowing loan forgiveness for rural providers in financial distress.

In conjunction with the AAOS Office of Government Relations, AAHKS has also been successful in helping to roll-back and/or ease the regulatory burden of multiple governmental policies and programs. Some of these include: issuing $34 billion in Medicare Accelerated and Advanced Payments, allowance of expansion of physician-owned hospitals, delay in reporting for the 2019 Merit-Based Incentive Payment Program, implementation of Good Samaritan protections for healthcare providers treating patients with COVID-19, and easing of the Health Insurance Portability and Accountability Act rules governing telemedicine.

A fourth stimulus package is currently being debated by members of Congress. On April 10, AAHKS signed on to a letter from AAOS sent to Senate Majority Leader Mitch McConnell (R-KY) and Speaker of the House of Representatives Nancy Pelosi (D-CA). In an effort to ensure survival of orthopaedic practices, AAHKS requests included: directing the Department of Health and Human Services and well as the Department of Treasury to prioritize CARES relief for practices in communities at risk of losing musculoskeletal care should practices close, delay the recoupment deadline until after 2021 in the Accelerated and Advance Payment Program, clarify tax liability receipts, and allow for loan forgiveness for affected practices. Additional requests included passing the Immediate Relief for Rural Facilities and Providers Act introduced by Senators John Barrasso, MD (R-WY) and Michael Bennet (D-CO), expanding eligibility in the Paycheck Protection Program to allow practices with greater than 500 employees to maintain staff, expanding language on Good Samaritan coverage in CARES to include physicians not working in their specialty who aren't volunteering (re-deployment), and ensure that the Families First Coronavirus Response Act covers physicians, healthcare workers, and first responders for paid sick leave.

Although we have temporarily pivoted much of our efforts to COVID-19 relief, we have also continued our traditional advocacy efforts. The potential of a change in value for Current Procedural Terminology codes 27447 (primary total knee arthroplasty) and 27130 (primary total hip arthroplasty) remains a significant focus of our advocacy efforts since initial suggestions of greater than 20% reductions were articulated. We have continued advocacy efforts around the significant amount of work done pre-joint replacement as well as the fact that operating room time has not decreased. Our practices cannot tolerate decreased CMS reimbursements for the valuable work we do, especially during a time of economic peril.

In addition, we continue to seek further clarification and audit protection for the challenge of coding total knee replacement, and now total hip replacement, as inpatient or outpatient as both have been removed from the Medicare Inpatient Only list. AAHKS and AAOS discussed this on a call with CMMI on April 16, 2020 and discussions concerning the value-based bundle payment programs and the confusion around interpretation of the two-midnight rule and hospital reimbursement occurred.

Based on current trends of how COVID-19 will continue to impact the United States in the coming months, we are currently discussing advocacy approaches to the lifting of formal mitigation efforts to “reopen” our economy. We are anticipating a phased roll-out once the data are convincing enough that it is safe to do so. Much discussion remains on how best to navigate the competing interests of reopening the economy and eradicating the virus. Increasing testing capacity, contract tracing networks, PPE supply and treatments are essential to minimize a surge in new COVID-19 cases.

In summary, AAHKS is committed to its mission of Advocacy. We will continue to inform you of our efforts on behalf of our AAHKS members, their practices, and their patients in these unprecedented times. We continue to encourage our members to be involved at the local, state, and national levels.